

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005729	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/08/2016
NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 7365 E 16TH ST INDIANAPOLIS, IN 46219		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00203909.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00199067 completed May 13, 2016.</p> <p>Complaint IN00203909- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey Date: July 7 and 8, 2016</p> <p>Facility number: 005729 Provider number: NA AIM number: NA</p> <p>Census bed type: Residential: 56 Total: 56</p> <p>Census payor type: Medicaid: 52 Other: 4 Total: 56</p> <p>Sample: 4</p> <p>Crownpointe of Indianapolis was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00203909.</p> <p>Quality review completed by 30576 on July 11, 2016</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE